Ellen Simon, LPC
Biofeedback & Hypnotherapy
17766 Preston Rd.
Dallas, TX 75252
Zenden.net
www.imadulation.com
ellensimon@imadulation.com
Telephone 972-880-0102
Fax 888-559-3543

DATE: _____

Name: _____ DOB: _____

Address: _____ City:_____ State: _____ ZIP: _____

Preferred Phone: _____ Email Address:_____

☐ Male ☐ Female ☐ Married ☐ Single

IF PATIENT IS A MINOR ---- Complete This Section

Responsible Party: _____ *Relationship to patient:* _____

Address, if different from patient's: _____

Home Phone: _____ *Work:* _____ Cell: _____

****

IN CASE OF EMERGENCY, CONTACT: _____
phone:_____

How did you hear about Ellen Simon? _____

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifies health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect o your protected health information, which you can exercise by representing a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identifies by you. We are, however, not required to agree to a requested restriction. If we do agree to a written request to the Privacy Officer:

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend you protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon requests.

We are required by low to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 1, 2004 and we are required to bide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have read a copy of the **Notice of**
(Name of Patient)

Privacy Practices from Ellen Simon, LLC. This notice describes how Ellen Simon, LLC may use and disclose

my protected health information, certain restrictions on the use and disclosure of my healthcare

information, and rights I may have regarding my protected health information.

_____ _____
Signature of Client, or Personal Representative Date

_____
Relationship to Client

_____
Print Name of Client

Name: _____ Date: _____

COMPREHENSIVE ASSESSMENT QUESTIONAIRE – ADULT

PRESENTING HISTORY

What is the main problem that caused you to seek help?

_____
_____
_____
_____

Why did you decide to seek help now?

_____
_____
_____
_____

Describe the main symptoms that are causing problems for you:

_____
_____
_____
_____
_____
_____
_____
_____

When did the problem first begin?

_____
_____
_____

Describe any stresses in your life that may have contributed to the problem: _____

_____
_____
_____
_____
_____

Please check the statement that best describes the course of the problem:

□ __The problems have stayed about the same since they started.
□ __The problems have steadily worsened since they started.
□ __The problems seem to come and go. At times I feel almost back to my usual self then the problems come back.
□ ___The problems have ups and downs but haven't gone away completely since they started.

Describe the history of the problem from its onset until now:

_____
_____
_____
_____
_____
_____
_____
_____

Have you had a similar problem in the past? □ Yes □ No If so, please describe the episodes and the dates they occurred.
_____
_____
_____
_____

Were you treated for this problem? □ Yes □No If so, please describe the treatment you received.
_____
_____
_____
_____
_____
_____
_____
_____

Has this problem caused you to experience any decrease in your ability to function in the following area?
If so, please describe:

School performance:
_____
_____
_____
_____
_____

Work performance:
_____
_____
_____
_____
_____

Relationship with spouse/significant other:
_____
_____
_____
_____
_____

Functioning as a parent:
_____
_____
_____
_____
_____

Social Life:
_____
_____
_____
_____
_____

Ability to manage chores at home:
_____

_____
_____
_____
_____

MEDICATION HISTORY

Please list all medications you are currently taking:

Prescription Medication	Dose	Start Date (MMYY)

Over the counter medications:

Type	Dose	Frequency of Use

Allergies to Medications:

Medication	Type of Allergic Reaction

MENTAL HEALTH HISTORY:

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name	Dates of Treatment

Medications prescribed in the past?

Medication	Dates	Response

Have you ever attempted suicide? □Yes □No If yes, please describe the nature of the event and the date(s) of occurrence.

_____
_____
_____
_____

MEDICAL HISTORY:

Who is your primary care physician? _____

Date of last visit: _____ Date of last physical: _____

Have you had any of the following:

□Heart Disease □Hypertension □Lung Disease □Thyroid Problems
□Diabetes □Asthma □Seizures □ Arthritis
□Kidney Disease □Liver Disease □Cancer □ Chronic Pain
□Other

_____
_____
_____

Please list details of any of the above you have checked or any other health problems: _____
_____
_____
_____
_____
_____
_____
_____
_____

List any surgery you have had:
_____
_____
_____
_____
_____
_____

WOMEN ONLY:
List any gynecological problems you have had: _____
_____
_____
How many pregnancies have you had? _____
How many children do you have? _____ Are you currently pregnant? □Yes □No
Are you planning to become pregnant in the near future? □Yes □No

FAMILY HISTORY:

Psychiatric History (List any blood relatives who have had emotional problems such as depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems)

Problem	Relative	Maternal Side	Paternal Side	Hospitalized?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medical History (List any physical problems that have run in your family)

Problem	Relative	Maternal Side	Paternal Side	Treatment

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Substance Use: Do you use any of the following?

Substance	Yes	No	Amount	Frequency Daily	Frequency Weekly	Date Last Used
Tobacco	☐	☐	_____	☐	☐	_____
Caffeine	☐	☐	_____	☐	☐	_____
Alcohol	☐	☐	_____	☐	☐	_____
Marijuana	☐	☐	_____	☐	☐	_____
Cocaine		☐	☐ _____	☐	☐	_____
Amphetamines	☐	☐	_____	☐	☐	_____
LSD	☐	☐	_____	☐	☐	_____
Pain Killers	☐	☐	_____	☐	☐	_____
IV Drug Use	☐	☐	_____	☐	☐	_____

Have you ever felt that you were abusing drugs or alcohol? ☐Yes ☐No

If so, describe when and the nature of the problem. _____
_____
_____

Have you tried to stop drinking? ☐ Yes ☐ No If yes, what was the outcome? _____
_____

Have you ever attended AA? ☐Yes ☐ No ☐Past ☐Current If yes, do you have a sponsor and how often do you attend meetings? _____

Have you ever attended NA? ☐Past ☐Current If yes, do you have a sponsor and how often do you attend meetings?
_____

SOCIAL HISTORY

Date of Birth: _____ Current Age: _____ Place of Birth: _____

Where did you grow up? _____

Please list your siblings and their current ages: _____
_____
_____

Are you close to your siblings? _____

Describe your father: _____
_____

How would you describe your relationship with your father? _____
_____

Describe your mother: _____
_____

How would you describe your relationship with your mother? _____
_____

Describe your childhood: _____
_____
_____
_____

Were your parents divorced? _____ If so, how old were you? _____
Who did you live with after the divorce? _____
Did your mother remarry? □Yes □No Did your father remarry? □Yes □No
What was your relationship with the stepparent(s)? _____
_____

Were you ever subjected to any type of abuse? (emotional, physical, sexual) If so, please describe the events.
_____
_____

How old were you at the time of the abuse? _____

Have you lost a close family member or friend? □Yes □No Who? _____ When? _____

Do you have a history of any legal problems? □Yes □No Describe: _____
_____

EDUCATIONAL HISTORY

How did you do in school? _____ Did you complete high school? □Yes □No
What kind of grades did you receive in school? _____
How did you get along with your peers? _____
How did you get along with your teachers? _____
Did you attend any special educations classes? □Yes □No _____
Were you required to repeat any classes or grades? _____
Did you attend college? □Yes □No Where? _____ Degree? _____ Year_____

OCCUPATIONAL HISTORY

Are you currently working? □Yes □No What is your occupation? _____
What is your current position? _____ Where do you work? _____
How long have you been there? _____ Are you satisfied with your job? □Yes □No
If no, please explain. _____
_____
List your last two jobs and how long you were employed there: _____
_____
Have you ever been fired? □Yes □No If so, please explain: _____
_____
Describe any current job stresses you may be experiencing: _____
_____
How well do you get along with co-workers? _____ Supervisors? _____

RELATIONSHIP HISTORY

Are you currently □Single □Married □ Divorced □Widowed □Other: _____
How long? _____ What is your sexual orientation? _____ Describe your relationship with your spouse or significant other. _____
_____
_____

List any stresses or problems in your relationship: _____
_____
_____

If married, what is your spouse's occupation? _____ Where employed? _____
Have you been married before? (or long term committed relationship) □Yes □No How many times?_____
How long did these relationships last? _____
Please describe the reason for the break-up or divorce(s). _____
_____
_____
Do you have children? □Yes □No List their names and ages: _____
_____
_____
Describe any problems you may be experiencing with your children: _____
_____
_____
Please list everyone currently living in your home: _____
_____
_____

What is your religious preference? _____

Do you actively attend religious services? □Yes □No Where? _____ How often: _____

Hobbies: _____

Are you currently involved in any clubs or organizations? □Yes □No List: _____

WELCOME!

This packet contains important information about my professional services and your rights as a client. Your signature on the last page indicates that you have received this and that you agree to enter into a professional relationship. Our first visit following the complimentary consult indicates I have accepted the responsibility to work with you professionally.

Client Information and Professional Disclosure

Counselor's Professional License and Training I am here to support your well being, to do my best to reduce any suffering and to assist you in the journey of greater understanding of yourself, your situation and your feelings. It is through this experience, and an increased awareness that you may grow and move toward the direction of your higher ideals and goals. I, Ellen Chernoff Simon, received a Bachelors degree in Humanities from The University of Texas in Austin in 1978, a masters degree in therapeutic recreation from Memphis State University in 1980, a masters degree in counseling from Memphis State University in 1981. I have a current active license as a Texas State Board Professional Counselor. I am board certified in both biofeedback and neurofeedback by the Biofeedback Certification International Alliance, a fellow of the Academy of Integrative Pain Management, a certified guide by the Academy of Guided Imagery, certified in aromatherapy with the Aromahead Institute, Certified in energy therapies: Thought Field Therapy and MASERS and certified in the movement practice of Nia as a blue belt and in Moving to Heal. I have completed three levels of reiki training. My training and experience in hypnotherapy has been received from the American Psychotherapy and Medical Hypnosis Association, the American Association of Medical Hypnoanalysis, and the North Texas Society of Clinical hypnosis and am certified as clinical hypnotherapist with the American Society of Clinical Hypnosis. **Theoretical Approach:** My approach is influenced by mind/body philosophy. Inspired by Milton Erickson, Carl Rogers, Victor Frankl, and Carl Jung, I use an approach that combines biofeedback, hypnosis, brain wave biofeedback, (also called neurofeedback), interactive guided imagery, hypnotherapy and depth psychotherapy. Supporting your goals by identifying both obstacles and strengths; accessing, then building on unconscious resources, we work together as a team to release negative patterns and to develop and restore a natural and healthy plan for wellness and peace. Research indicates relationships are the most important factor in happiness and the most crucial relationship you have is with yourself, so we will explore and enhance that one first! Our work together can also include goal setting, drawing, life timeline, relaxation training, hypnotic suggestion, movement, and aromatherapy. I will make observations about your situation(s) and offer suggestions for new ways to approach them. I will encourage deeper self exploration to encourage solutions to be found from within. While we can offer many possible alternatives, it is always your responsibility to decide what is best for you. For the best results, you will be honestly exploring your own feelings and thoughts and trying new approaches to your old problems. The most effective changes will be in your perspective, or how you see the concerns, conflicts or symptoms you are experiencing.
Risks of Therapy. Therapy is the Greek word for change. Services are expected to offer a combination of methods for evaluating choices, behavior, and direction in everyday

life and require dedication and commitment. The expectation is to promote physical and mental/emotional well being. Risks associated with therapeutic techniques are common to all forms of therapy, in that resistance, poor rapport and/or external constraints may interfere with effective therapy. Effective therapy is often uncomfortable as sensitive issues may need to be explored or challenged. Every effort will be made to support and consider your individual needs. Counseling does not give answers, it provides an opportunity to discuss concerns with a trained licensed professional for the purpose of gaining a better understanding and deeper awareness of conflicts, problems and issues which ideally leads to self acceptance, self knowledge and unfolding growth and potential. In spite of the risks, knowing yourself and what you need to be fulfilled will ultimately allow you to have closer, more genuine relationships with self and others. Confidentiality is defined as keeping the information you share with your therapist private. We believe you have a right to privacy and that your therapy results depend on your trust and ability to share your thoughts and feelings safely. Discussions between you and me and even the fact that you are in counseling with me are confidential. For this reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first. I will also keep a written record of our visits, which is also confidential. There are limits to confidentiality at which point I would be required to break confidentiality. Those instances include (Legal Confidentiality Limitations in Texas) 1. If your records are subpoenaed by a court, we are not legally empowered to deny the subpoena. We will have to provide your records. 2. We are legally compelled to notify authorities if you are, or are involved in a. A danger to yourself or others. b. On-going child or elder abuse. c. Abuse of patients in care facilities. d. Sexual exploitation. 3. Court proceedings to collect fees 4. Licensing Board investigations. 5. HIPPA investigations. As of now, this practice does NOT file insurance claims, but rather will provide you with a receipt to submit the claim on your own. Files are closed once the counseling relationship ends and will remind confidential.

General Release of Information:

There are times when it is helpful to communicate with other individuals and professionals to enhance outcomes. I agree to allow Ellen Simon to release information to the following individuals listed below:

_____

_____

Client signature_____

Therapy Plan: You will be creating a therapy plan with your therapist in order to maximize your results. First, your therapist will assist in establishing your goals. The therapy plan will be designed to accomplish your goals as quickly as possible. Your plan may include the number and frequency of sessions, types of sessions and the scope of the process. As a team, you and your therapist will decide what is reasonable and practical for your circumstances. The practical considerations will include all aspects of your unique situation and resources.

Emotional Support Dog: On occasion Ellen Simon may have her golden doodle present at the session. If you prefer the animal to be in session with you please initial_____. By signing you also agree to hold harmless both Ellen Simon and her dog if any unforeseen or unexpected event occur such as an allergy or mishap with the dog.

Appointments: You and your therapist will decide on mutually acceptable times to meet. The frequency of appointments and duration of each session will be mutually agreed upon.

Typically appointments are scheduled weekly in the beginning then may taper off. Therapy appointments are 50- 80 minutes in length and must conclude on time, even if you are late. Your therapy time is reserved for you so please call to cancel or reschedule at least 24 hours in advance. Appointment Location: Ellen Simon's current office is located at 17766 Preston Rd. #205. All appointments are scheduled there unless a movement session is requested and that may be at a scheduled at another location.

E-Mail/ Text Messaging:

I am available by email or text. Please remember this form of communication is not secure, so be careful about the information you choose the send in this format. The initial forms are sent via email to be printed out and completed before the initial session. Termination/ Complaints: Periodic re-evaluations to assess the efficacy of counseling will be discussed. A client has the right to terminate without notice at any time. If a counselor is unable to provide services, or deems the patent in need of more specialized services, referrals must be made to other professionals. If at any time a client is dissatisfied with services, it is preferred that this be reported first to the counselor, as such feedback may benefit others. A formal complaint may be made to the Texas State Department of Health Services **Referrals:** At any time during the service it may be appropriate to refer a client to another professional. Ellen Simon does not receive monetary or any other compensation for providing referrals. The risks and benefits of the referral must be evaluated by the client and the choice whether or not to proceed is entirely individual. Ellen Simon has no influence or responsibilities for the fees of outside service providers. **Emergencies/ Availability and Limitations** An emergency is an urgent issue requiring immediate action. If you are in a life threatening emergency or feel you may harm yourself or someone else, please call 911, the MHMR crisis line Denton, Collin, Tarrant county 800-762-0157 or Dallas County 866-260-8000 or have a trusted person bring you to the ER. Occasionally, an emergency requires telephone counseling. Your therapist is on call 24 hours a day, seven days a week and most of the time can be reached

via emergency numbers provided to you. In the event your therapist can not be reached, please follow the steps above. While you are encouraged to call in an emergency, please be informed that telephone counseling is treated as in office counseling. Typically, a one hour office visit charge is expected for emergency telephone counseling.

Please provide me with your emergency contact name and number:

_____ _____

Payment for Services Payment is due at the time services are rendered.

Payment is accepted by check, cash or credit card.

Please make payment to Ellen Simon.

*Individual session $120……..50 minutes $180……..80 minutes

CONSENT TO TREATMENT: I voluntarily agree to receive mind/body health assessment, care, treatment, or services and authorize the undersigned therapist to provide such care treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services and that I may stop such care at any time. By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____

Client's Signature

_____

Date as witnessed by: Therapist who has inquired about questions, confirmed that the client has read and understood the entire form and all questions have been answered to client's satisfaction.

_____

Therapist's Signature Date

STRESS SIGNALS

Name_____Date_____

Check off the items you experience.

Physical Changes
__Heart Palpitations/fast pulse
__Shortness of breath
__Tight muscles
__Headache (feels like a tight band around the forehead, feels like the scalp it too small for the skull)
__Upset stomach
__Indigestion
__Sweating
__Cold, clammy hands
__Cold feet

Emotional Changes
__Lack of energy
__Tearfulness
__Decreased in Self-esteem
__Easily angered
__Irritable
__Worried

Behavioral Changes
__Eating more or less
__Binge eating
__Increased use of tobacco, alcohol or drugs (circle one)
__Insomnia, broken sleep, early awakening, or increased sleeping (circle one)
__Increased illness or injury (circle one)
__Poor concentration
__Memory Loss
__Decreased ability to communicate effectively
__Decreased creativity/productivity
__Decreased time with family and friends
__Decreased attention to personal appearance
__Inability to stop thinking about one particular idea

BAI

NAME _____ DATE _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

THE PSYCHOLOGICAL CORPORATION